QA 57 – Extreme "Pickiness"

QUESTION:

During the past 2-3 years, I have seen several patients with a problem of limited food selection outside the norm of a "picky eater". Although this sounds like a control issue, these kids present with the desire to broaden their food preferences, but inability to do so without gagging or vomiting, or "feeling ill" with the introduction of new foods. Their diets are limited to mainly carbohydrates, but may include enough protein to "get by". They are taking vitamin supplements as they acknowledge the lack of variety and nutrition in their diet. Typically they have about 10 "regular" foods that they will consume, and if these are not made available, some of them just simply don't eat. They are not intentionally starving themselves, nor do they have impaired body images. One Mother slowly withdrew the favorite foods and replaced them with other foods; meanwhile her 11 year old (already thin) daughter lost even more weight. She relented with the favorites for fear of creating an eating disorder. Mom states, "she was born this way". There are no other signs of sensory issues upon evaluation by our speech therapist. We have tried traditional therapy, setting small doable goals with the speech therapist, giving meal times more structure, and peer pressure types of situations. We do not have a behaviorist available. What suggestions do you have, have you seen this before to this extent?

ANSWER:

The patients described are probably more common than we in health care want to believe. Many children and adults who have become accustomed to a very low food variety carry out normal lives without placing themselves at any significant physiologic risk. On the other hand some children and parents may organize much of their life and energy around the need for a healthy diet with adequate variety. Food variety is of course an undisputed healthy goal but in fact is much more difficult for some people than others. And for those with a particular problem in food variety, a parent's focus and heightened concern only exacerbates the problem.

Once traditional medical causes within the child's neurological system and anatomy have been ruled out, the remaining question is "What purpose does the child's behavior to new foods serve?" The answer often lies within information not readily available to an RD or a speech pathologist but comes from a greater look at the child's temperament, individual emotional health, and the families' overall emotional environment. Such an evaluation is best completed by a psychosocial professional with experience in disordered eating behaviors and eating disorders. If a child otherwise presents with no significant physiologic risk (i.e. the child's weight is age/ht appropriate, and is able to "get by" with vitamin and mineral supplementation) many Pediatricians and Children Providers (PCP's) and parents opt to forego the time and expense and exposure of an in-depth psychosocial evaluation and treatment.

Behavioral and psychosocial studies for children of all ages indicate that there is a strong correlation between a child and parent's temperament and developing emotional health to a variety of behaviors and at times psychosomatic symptoms around food. Documented behaviors and psychosomatic symptoms include, but are not limited to, overeating, food

quantity restriction, food variety restriction, gagging, vomiting and reports of feeling ill or experiencing stomach pains. If behaviors around food limit or increase intake for a duration when a patient is at physiologic risk, the patient is considered to have a non-specific eating disorder. If the patient is not at risk for physiologic complications the behaviors are better classified as general disordered eating. In either case and without psychosocial treatment a patient may not necessarily be able to determine whether behaviors and symptoms are voluntary or not. They may furthermore report rather extensive past efforts and real desire to rid themselves of the adverse food reactions. Patients with various adverse food reactions who are otherwise physiologically healthy and functioning well in life may possess a generally anxious, rigid, or internally intense temperament that causes them discomfort when embarking on new foods, events and concepts in general. Subtle mental health, temperament or neurological issues often do not fall within traditional diagnosis parameters because the child and/or family may have adapted or accepted similar behaviors in other arenas of the child's life. The mother described in the question stating "she was born that way" in this sense may have been accurate. Adverse feeding and food behaviors are often observed in children with obsessive compulsive (OC) traits. Similar to anxious children, a child with OC traits may experience such an adverse internal response to unfamiliar foods that they feel ill, gag or vomit. For many other children limiting food variety may be related to a long term maladaptive coping strategy for a variety of past and present social developmental challenges.

Specific recommendations:

1) If warranted by parental or child interest, distress or physiologic risk, recommend further evaluation and treatment by a psychosocial professional.
2) Help the child (depending on age) and parent to identify one food preference in each food group.
3) Provide specifications on meal/snack frequency and daily food quantity goals to assure adequate KCAL and protein.
4) Provide much assurance to the child's parent that with the identified foods/amounts and vitamin/mineral supplementation as needed that the child will meet nutrient needs and gain and grow normally.
5) After psychosocial input assess/discuss behavioral strategy. Often once a dialogue between child/parent and psychosocial professional has started the child will feel more mobilized to work on making their diet more flexible, but only with considerable support and understanding about how difficult the situation may be for the child.
6) Goals of nutrition progress are very slow...much ground work may be done before the child feels comfortable enough to identify a food they are willing to begin including in their diet. Once identified, the child would be expected to first tolerate the food on their plate, then touch it, then taste it, then take two bites, etc. Some children and adolescents may only successfully tolerate one new food per month or every two months.
7) Applaud the most minimal success in all of the above.

References:

1) York B. Early Age Eating Disorders. Nutrition Focus. Vol. 16(2), 2001 (March/April).
2) Garner D and Garfield. Handbook for Treatment of Eating Disorders, New Guilford Press.
3) Kessler D and Dawson P. Failure to Thrive and Pediatric Undernutrition. Brookes Publishing, 1999.